



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ERIC A. VANDERWERFF, D.C.

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-16-3215-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

JUNE 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The physical therapy services rendered on above dates of service were pre-authorized by the carrier...approved by the insurance carrier and according the ODG guides, and MUST BE PAID."

Amount in Dispute: \$1,519.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Office respectfully requests the Division to dismiss the request for dispute pursuant to Rule §133.307(f)(3)(C) as there are unresolved compensability, extent of injury or liability disputes on this claim for the dates of service eligible for resolution."

Response Submitted by: SORM

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 10, 2015 June 18, 2015 July 2, 2015	CPT Code 98943 Chiropractic Manipulation Services	\$50.00/ea	\$130.50
June 10, 2015 June 11, 2015 June 18, 2015 June 24, 2015 July 2, 2015	CPT Code G0283-GP Physical Therapy Services	\$24.00/ea	\$82.00
June 10, 2015 June 11, 2015 June 18, 2015 June 24, 2015 July 2, 2015	CPT Code 97110-GP (x4) Physical Therapy Services	\$210.24/ea	\$844.15
June 11, 2015 June 24, 2015	CPT Code 98940 Chiropractic Manipulation Services	\$50.00/ea	\$89.80
June 11, 2015 July 2, 2015	CPT Code 97140-59-GP Physical Therapy Services	\$49.20/ea	\$72.76
TOTAL		\$1,519.60	\$1,219.21

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 119-Benefit maximum for this time period or occurrence has been reached.
 - 163-The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
 - 168-Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services.
 - 219-Based on extent of injury.
 - 309-The charge for this procedure exceeds the fee schedule allowance.
 - P12-Workers compensation jurisdictional fee schedule adjustment.
 - W3-Additional payment made on appeal/reconsideration.

Issues

1. Does an extent of injury issue exist in this dispute? Is the dispute eligible for review?
2. Is the requestor entitled to reimbursement for chiropractic and physical therapy services?

Findings

1. According to the submitted explanation of benefits, the respondent denied reimbursement for chiropractic and physical therapy services rendered on June 10, 2015 through July 2, 2015 based upon "219-Based on extent of injury."

The respondent contends that reimbursement is not due because "the Office respectfully requests the Division to dismiss the request for dispute pursuant to Rule §133.307(f)(3)(C) as there are unresolved compensability, extent of injury or liability disputes on this claim for the dates of service eligible for resolution." In support of their position, the respondent submitted copies of DWC Form PLN-11's that dispute the following conditions:

- September 14, 2012- Acromioclavicular degenerative disease , subacromial spur, degenerative humeral cysts at the insertion of the infraspinatus tendon of your left shoulder and left carpal tunnel syndrome; and
- November 29, 2012 -Reflex sympathetic disorder (RSD) to the left upper extremity and sleep apnea.

The requestor asserts that reimbursement is due and submitted a copy of the May 20, 2014 Contested Case Hearing Decision that found the compensable injury "extends to and includes left shoulder internal derangement, bicep tendon tear, partial rotator cuff tear, brachial neuropathy, and left upper extremity reflex sympathetic dystrophy/chronic regional pain syndrome."

The requestor did not document in the Patient Daily Note reports that the disputed treatment was for any condition disputed on the PLN-11s; therefore, the Division finds that an extent of injury issue does not exist and the disputed services are eligible for review by MFDR.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section,

shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

On the disputed dates of service, the requestor billed the following services:

- CPT code 98943- Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions.
- CPT code G0283-GP- Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.
- CPT code 97110-GP- Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
- CPT code 98940- Chiropractic manipulative treatment (CMT); spinal, 1-2 regions.
- CPT code 97140-59-GP- Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes.

The requestor appended modifier “GP- Services delivered under an outpatient physical therapy plan of care,” and “59- Distinct Procedural Service” to codes as noted above.

CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011 which states in part “Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings.” The multiple procedure rule discounting applies to the disputed services.

Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061, which is located in Irving, Texas; therefore, the Medicare participating amount is based on locality “Dallas, Texas”.

The 2015 DWC conversion factor for this service is 56.2.

The 2015 Medicare Conversion Factor is 35.9335.

Using the above formula and multiple procedure rule discounting, the Division finds the following:

CODE	MEDICARE PARTICIPATING AMOUNT	NO. OF UNITS	MAR	NO. OF DATES	AMOUNT DUE
98943	\$27.67	1	\$43.50	3	\$130.50
G0283	\$14.04	1	\$22.07 X MPR = \$16.40	5	\$82.00
97110-GP	\$32.80/ea 15 min	4	\$51.56 X MPR X 4 = \$168.83	5	\$844.15
98940	\$28.56	1	\$44.90	2	\$89.80
97140-59-GP	\$30.51	1	\$47.42 X MPR = \$36.38	2	\$72.76

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,219.21.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,219.21 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	09/02/2016 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.